570

Medicare

Budget function 570 comprises spending for Medicare, the federal health insurance program for elderly and eligible disabled people. Medicare consists of two parts, each tied to a trust fund. Hospital Insurance (Part A) reimburses health care providers for inpatient care that beneficiaries receive in hospitals as well as for care at skilled nursing facilities, some home health care, and hospice services. Supplementary Medical Insurance (Part B) pays for physicians' services, outpatient services at hospitals, home health care, and other services. CBO estimates that Medicare outlays (net of premiums paid by beneficiaries) will total $248 billion in 2003. That amount includes discretionary outlays of almost $4 billion, which are for the administrative expenses of operating the Medicare program. Mandatory outlays for Medicare have more than doubled since 1990.

Federal Spending, Fiscal Years 1990-2003 (In billions of dollars)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Estimate 2003
Budget Authority (Discretionary)	2.4	2.6	2.9	2.8	3.0	3.0	2.9	2.6	2.7	2.8	3.0	3.3	3.8	3.6
Outlays														
Discretionary	2.3	2.4	2.8	2.7	2.9	3.0	3.0	2.6	2.6	2.8	3.0	3.3	3.2	3.8
Mandatory	95.8	102.0	116.2	127.9	141.8	156.9	171.3	187.4	190.2	187.7	194.1	214.1	227.7	244.6
Total	98.1	104.5	119.0	130.6	144.7	159.9	174.2	190.0	192.8	190.4	197.1	217.4	230.9	248.4
Memorandum:														
Annual Percentage Change in Discretionary Outlays	n.a.	6.3	16.4	-6.9	10.0	2.0	-0.6	-12.8	0.5	6.3	8.9	10.8	-5.0	16.3

Note: n.a. = not applicable.

570-01—Mandatory

Reduce Medicare's Payments for the Indirect Costs of Patient Care That Are Related to Hospitals' Teaching Programs

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	2,600	3,000	3,200	3,500	3,700	16,000	38,500

The Social Security Amendments of 1983 established the prospective payment system (PPS) under which Medicare pays hospitals for inpatient services provided to its beneficiaries. The program pays higher rates to hospitals with teaching programs to cover their higher costs of caring for Medicare patients. In 2003, the additional percentage that those hospitals receive averages about 5.5 percent for each increase of 0.1 in a hospital's ratio of full-time residents to its number of beds.

The additional payments to teaching hospitals are designed to compensate them for indirect teaching costs—such as the greater number of tests and procedures that residents are thought to prescribe—and to cover higher operating costs from factors not otherwise accounted for in setting the PPS rates. Such factors might include a greater number of severely ill patients, an inner-city location, and a more costly mix of staffing and facilities, all of which are associated with hospitals that have large teaching programs.

The Medicare Payment Advisory Commission has estimated that a 2.7 percent adjustment to Medicare's payments would more closely match the increase in operating costs associated with teaching. This option would lower the teaching adjustment accordingly, saving $2.6 billion in 2004 and $16 billion over five years.

Supporters of this option contend that it would better align payments with the actual costs that teaching institutions incur. Furthermore, proponents maintain, since the training that medical residents receive will significantly increase their future income, and since hospitals benefit from using residents' labor, it is reasonable for some or all of a hospital's indirect training costs to be borne by both residents and the hospital. (Residents already bear some of those costs in the form of stipends that are lower than the value of their services to a hospital.)

Critics of this option argue that a lower teaching adjustment would probably lead to smaller residency programs. In addition, if teaching hospitals now use some of their payments to fund activities such as charity care, this option could reduce access to medical services for people without health insurance.

RELATED OPTIONS: 550-09, 570-02, 570-03, and 570-04

RELATED CBO PUBLICATION: *Medicare and Graduate Medical Education*, September 1995

570-02—Mandatory

Reduce Medicare's Direct Payments for Medical Education

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	800	1,000	1,000	1,000	1,000	4,800	10,500

Medicare's prospective payment system does not include payments to hospitals for the direct costs they incur in providing graduate medical education (GME)—namely, residents' salaries and fringe benefits, teaching costs, and institutional overhead. Instead, Medicare makes those payments separately on the basis of its share of a hospital's 1984 cost per resident, indexed for increases in the level of consumer prices. Medicare's direct GME payments, which about one-fifth of U.S. hospitals receive, totaled $2.4 billion in 2002.

Under this option, hospitals' direct GME payments would be based on 120 percent of the national average salary paid to residents in 1987, updated annually for changes in the consumer price index for all urban consumers. In effect, this option would reduce teaching and overhead payments for residents but continue to pay their salaries and fringe benefits. The option would also maintain the current-law practice of reducing payments for residents who have gone beyond their initial residency period. The savings from this option would total about $800 million in 2004 and $4.8 billion over the 2004-2008 period. Unlike the current system, in which GME payments vary considerably from hospital to hospital, this option would pay every hospital the same amount for the same type of resident. (Although the Congress recently took action to lessen some of the variation among hospitals in payments per resident, considerable differences remain.)

Advocates of this option argue that an overall reduction in the level of federal subsidies for medical education might be warranted because market incentives appear to be sufficient to encourage a continuing flow of new physicians. Moreover, since hospitals use resident physicians to care for patients, and since residency training helps young physicians earn higher incomes in the future, both hospitals and residents might reasonably contribute more to those training costs than they do now. Residents would contribute more to those costs if hospitals responded to the change in reimbursement by cutting residents' salaries or fringe benefits.

Opponents of this change note that if hospitals lowered residents' salaries or benefits, the costs of longer residencies—in terms of forgone practice income—could exert greater influence on young physicians' decisions about pursuing a specialty. More residents might choose to begin primary care practice rather than specialize further. That outcome could be negative for the individual resident (although the Council on Graduate Medical Education and other groups believe that a relative increase in the number of primary care practitioners would be desirable for society). Finally, decreasing GME reimbursement could force some hospitals to reduce the resources they commit to training, possibly jeopardizing the quality of their medical education programs.

RELATED OPTIONS: 550-09, 570-01, 570-03, and 570-04

RELATED CBO PUBLICATION: *Medicare and Graduate Medical Education*, September 1995

570-03—Mandatory

Eliminate Additional Capital-Related Payments for Hospitals with Residency Programs

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	200	200	200	200	200	1,000	2,500

Under the prospective payment system for inpatient hospital services, Medicare pays hospitals an amount for each patient discharged that is intended to compensate hospitals for capital-related costs. Currently, hospitals with teaching programs receive additional capital-related payments that are based on "teaching intensity," measured as the ratio of their residents to their average daily number of inpatients. An increase of 0.1 in that ratio raises a hospital's capital-related payment by 2.9 percent.

This option would eliminate those extra capital-related payments to teaching hospitals. Doing so would save the Medicare program about $200 million next year and $1.0 billion over the 2004-2008 period.

Proponents of this option argue that paying teaching hospitals more than nonteaching hospitals for otherwise similar patients may discourage efficient decisionmaking by hospitals. In addition, Medicare's payment adjustments for teaching intensity may distort the market for residency training by artificially increasing the value (or decreasing the cost) of residents to hospitals. If residents' training raises the costs of patient care for a hospital, supporters of this option argue, the hospital should bear those costs in order to encourage an efficient amount of training. Hospitals are likely to shift such costs to residents in the form of lower stipends or greater workloads. Residents will engage in such training if they perceive that their future productivity, as reflected in their future income, will be great enough to outweigh those costs.

Critics charge that eliminating the special capital-related payments would reduce revenues to teaching hospitals at a time when they already face pressure to cut costs in order to remain competitive. Teaching hospitals would probably have to reduce some services as a result, which could mean conducting less medical research or providing fewer services to people without health insurance.

RELATED OPTIONS: 550-09, 570-01, 570-02, and 570-04

RELATED CBO PUBLICATION: *Medicare and Graduate Medical Education*, September 1995

570-04—Mandatory

Convert Medicare Payments for Graduate Medical Education into a Block Grant and Slow Their Growth

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	400	700	900	1,200	1,600	4,800	18,400

Three types of Medicare payments to teaching hospitals are tied to the size or intensity of a hospital's residency program: direct graduate medical education (GME) payments (option 570-02); the indirect medical education adjustment for inpatient operating costs (option 570-01); and the indirect medical education adjustment for inpatient capital-related costs (option 570-03). Teaching hospitals now receive GME payments for participants in Medicare+Choice health plans in addition to their traditional payments for fee-for-service Medicare patients. Several variables determine the total amount of GME payments to a hospital, including the number and diagnoses of Medicare patients discharged and numerical factors used annually to update payments for inpatient operating costs and capital-related costs. Because of changes in those variables over time, the Congressional Budget Office expects GME payments to grow at an average rate of 6 percent a year between 2004 and 2013 under current law.

This option would replace the current payments with a consolidated block grant to fund the special activities of teaching hospitals. Under the present system, a hospital receives GME payments on the basis of formulas set forth in regulations, and Medicare's total GME spending is the resulting sum of what it owes each hospital. This option assumes that the switch to a block-grant program would occur in 2004 and that the amount of the grant would be based on spending in 2002, with increases for the overall rate of inflation. Compared with projected spending under current law, this option would reduce federal outlays by $400 million in 2004 and by $4.8 billion over the 2004-2008 period.

Advocates of establishing a block grant for the three types of GME payments argue that it would allow lawmakers to better monitor and adjust GME funding. In addition, Medicare would no longer pay different rates to hospitals for inpatient services merely because of differences in the size or presence of residency programs.

Opponents argue that because this option would reduce total payments to teaching hospitals below the amounts expected under current law, such hospitals would, on average, receive less revenue than they would otherwise. In response, teaching hospitals might reduce the amount or quality of some of their services, including medical research and care for people without health insurance.

RELATED OPTIONS: 550-09, 570-01, 570-02, and 570-03

RELATED CBO PUBLICATION: *Medicare and Graduate Medical Education*, September 1995

570-05—Mandatory

Convert Medicare Disproportionate Share Hospital Payments into a Block Grant

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	730	1,120	1,460	1,810	2,190	7,320	25,030

Hospitals that serve a disproportionately large share of low-income patients can receive higher payment rates under Medicare than other hospitals do. The Medicare disproportionate share hospital (DSH) adjustment was introduced in 1986 to account for what were assumed to be the higher costs of treating Medicare patients in such hospitals. Recently, however, the DSH adjustment has been seen mainly as a means to protect access to care for low-income populations by providing financial support to hospitals that serve a large number of low-income patients. Annual outlays for Medicare DSH payments rose rapidly between 1989 and 1997, reaching $4.5 billion. Restrictions established by the Balanced Budget Act of 1997 caused those outlays to decline for a few years, but they resumed growing in 2000. Last year, Medicare DSH payments totaled $5.2 billion.

This option would convert DSH payments into a block grant to states. In 2004, each state's grant would be 10 percent less than the estimated sum of Medicare DSH payments made to hospitals in that state in 2003. In subsequent years, the block grant would be indexed to the change in the consumer price index for urban consumers minus 1 percentage point. In return for the lower payments, states would gain more flexibility in how DSH funds were used. Those changes would decrease Medicare outlays by $730 million in 2004 and by $7.3 billion over five years. (The estimated savings include the fact that lower Medicare DSH payments would reduce payment updates to plans participating in Medicare+Choice.)

Supporters of this option argue that the added flexibility provided to states under this option could result in DSH funds' being targeted more appropriately and equitably to facilities and providers that serve low-income populations. For example, rather than going solely to hospitals, such funds might also be used to support outpatient clinics that treat low-income patients.

Critics of this option argue that state governments might not increase their subsidies to make up for the reduction in federal payments. As a result, hospitals as a whole could receive less in combined federal and state funding. Additionally, allowing states to allocate DSH payments could change the distribution of assistance among hospitals, possibly causing some large urban hospitals to receive less public funding than they do now.

RELATED OPTION: 550-05

570-06—Mandatory

Expand Global Payments for Hospitals' and Physicians' Services Provided During an Inpatient Stay

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	100	100	100	100	100	500	1,500

Under Medicare's prospective payment system (PPS), hospitals receive payments for the operating and capital costs of providing inpatient services to Medicare beneficiaries. Those payments are determined on a per-case basis: payment rates vary with the patient's diagnosis—which Medicare classifies using a system of diagnosis-related groups (DRGs)—and with the characteristics of the hospital. Those rates take into account reasonable variations in the treatment of patients within a given DRG and offer hospitals an incentive to reduce the cost of treatment. PPS payments do not cover all services rendered to patients during their hospital stay. In particular, Medicare pays separately for physicians' services provided on an inpatient basis.

This option would give hospitals the choice to receive a single global payment for high-cost, high-volume inpatient procedures—a change that has been explored by the Centers for Medicare and Medicaid Services. That payment would be lower than the separate payments now made for hospitals' operating costs and physicians' services, thus saving Medicare $100 million in 2004 and $500 million over the 2004-2008 period. The global payment would cover such procedures as heart bypass surgery, cataract surgery, coronary angioplasty, heart valve replacement, and joint replacement.

Advocates of this option note that during a demonstration project in the 1990s in which Medicare made global payments to seven hospitals for heart bypass surgery, Medicare outlays for those hospitals were about 10 percent lower, on average, than they would have been otherwise. In that demonstration, discounted payment rates were established through negotiations with participating hospitals in conjunction with teams of physicians. Supporters argue that global payments give both hospitals and physicians an incentive to reduce operating costs while maintaining a satisfactory standard of care. Hospitals could offset the declines in their Medicare payments by improving efficiency (with resultant cost savings) or by increasing their volume of patients (using new marketing efforts).

Opponents argue that this option would not be widely applicable because only a handful of hospitals perform a significant number of such high-cost, high-volume inpatient procedures.

570-07—Mandatory

Further Reduce the Medicare Prospective Payment System Update Factor for Hospitals' Inpatient Operating Costs

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	900	2,000	3,200	4,500	6,000	16,600	75,700

Under Medicare's prospective payment system (PPS), payments for hospitals' operating costs for inpatient services provided to Medicare beneficiaries are determined on a per-case basis, according to preset rates that vary with the patient's diagnosis and the characteristics of the hospital. Payment rates are adjusted each year using an update factor that is determined in part by the projected rise in the hospital market-basket index (MBI), which reflects increases in hospital costs. Changes in the MBI also affect payments for Medicare+Choice plans, because those payments are calculated taking into account Medicare's payments to hospitals.

Under current law, the hospital update factor for 2003 is the change in the MBI minus 0.55 percentage points. After 2003, the update factor reverts to the full change in the MBI.

This option would reduce the Medicare PPS update factor to the annual change in the MBI minus 1.1 percentage points. That rate would take effect in 2004 and continue through at least 2013. Savings from that reduction would total $900 million next year and $16.6 billion over five years (including savings from reduced payments to Medicare+Choice plans).

Supporters of this option argue that further reductions in the update factor are justifiable because hospitals' profit margins on Medicare inpatient services are relatively high. In 2002, when the update factor was also the change in the MBI minus 0.55 percentage points, hospitals were expected to have an average profit margin of about 11 percent on Medicare inpatient services. Furthermore, when the update factor has been lower in the past, hospitals have been able to maintain fairly high inpatient profit margins by achieving greater efficiencies. In 1999, for example, when the update factor was the change in the MBI minus 1.9 percentage points, those profit margins averaged about 12 percent.

Critics of this option note that Medicare inpatient profit margins are overstated because Medicare's payment systems have given hospitals an incentive to allocate too much of their overhead and ancillary costs to outpatient services. Thus, hospitals' profit margins on Medicare outpatient services are understated. (In 2002, those margins were expected to average about -16 percent.) Opponents of this option argue that hospitals' overall Medicare profit margins, which were expected to average about 4 percent in 2002, indicate that Medicare's total payments to hospitals for all services are reasonable. Therefore, critics argue, Medicare's payments for inpatient services should not be reduced without carefully evaluating the adequacy of payments for hospital outpatient services as well. Finally, critics say, even with inpatient margins overstated, about one-third of hospitals have negative profit margins on Medicare inpatient services; further reductions in the update factor could cause considerable hardship for those hospitals.

570-08—Mandatory

Further Reduce Medicare's Payments for Hospitals' Inpatient Capital-Related Costs

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	500	600	600	700	700	3,100	6,900

In 1992, Medicare switched its method of paying hospitals for the capital-related costs of inpatient services from cost-based reimbursement to a prospective payment system. Under that system, hospitals receive a predetermined amount for each Medicare patient to cover capital-related costs, which include depreciation, interest, taxes, insurance, and similar expenses for buildings and equipment. The prospective system for capital-related costs applies to about 5,000 hospitals that are also paid under Medicare's prospective payment system for operating costs. In both systems, a hospital's prospective rate is adjusted for its mix of patients and other characteristics.

Analyses by the Centers for Medicare and Medicaid Services (CMS) suggest that the prospective rates for capital payments set in 1992 were too high. Those rates were based on 1989 data projected to 1992, but in actuality, capital costs grew more slowly than expected between 1989 and 1992. Moreover, the level of capital costs per case in 1989 that was used to set rates was probably higher than would be optimal in an efficient market because of incentives created by the Medicare payments. Factors such as changes in capital prices, the mix of patients treated by hospitals, and the "intensity" of hospital services contributed to the overestimate, which the Medicare Payment Advisory Commission and CMS estimated at between 15 percent and 28 percent, with an average of about 22 percent. Consequently, the Balanced Budget Act of 1997 reduced the federal rate by 17.8 percent for capital payments made to hospitals for patient discharges occurring in 1998 through 2002. (A small part of that reduction, 2.1 percentage points, was restored beginning this year.)

This option would further reduce the prospective payment rate for hospitals' capital-related costs by 5 percentage points—bringing the total reduction to about 22 percent from the initial level. That change would lower Medicare outlays by $500 million in 2004 and $3.1 billion over the 2004-2008 period.

Proponents of lower payments note that Medicare's payments for capital costs are a small share (less than 5 percent) of hospitals' total revenues. Most hospitals would probably be able to adjust to the reductions by lowering their capital costs or partially covering those costs with other sources of revenue.

Opponents of this option argue that hospitals in poor financial condition could have difficulty absorbing the reductions. As a result, the quality of the care they offer could decline, and they might provide fewer services to people without health insurance.

570-09—Mandatory

Increase the Number of Postacute Care Discharges Treated as Hospital Transfers Under Medicare

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	300	400	400	400	500	2,000	4,800

Medicare's prospective payment system (PPS) pays hospitals for inpatient treatment of Medicare beneficiaries on the basis of the patient's diagnosis. The PPS amounts were developed using data on costs for an average length of stay in a hospital for each diagnostic grouping. Over time, the average length of stay has decreased, particularly for patients in certain diagnosis-related groups (DRGs) who are frequently discharged to postacute care settings, such as home health agencies and skilled nursing facilities. (In turn, Medicare's payments to postacute care providers have increased.)

Medicare reduces its payment to an admitting hospital if a patient is transferred from that acute care hospital to another for related care. The final discharging hospital receives full payment, whereas the admitting hospital receives a per diem payment not to exceed the full amount. Beginning in 1998, Medicare applied a similar policy to hospitals that discharge certain patients to postacute care settings. Specifically, hospitals receive reduced payments for patients in 10 DRGs who are transferred to a postacute care setting if their stay in the admitting hospital is shorter than the average length of stay for that DRG. Researchers evaluating the impact of that change found that it lowered Medicare payments in 2001 by about $400 million.

This option would extend the postacute transfer policy to a further 13 DRGs with the next-highest rates of discharge to postacute care facilities. Doing so would reduce Medicare outlays by $300 million in 2004 and $2.0 billion over five years.

Supporters of this option argue that extending the postacute transfer policy would not only save money for Medicare but also give hospitals greater incentive to ensure that patients were fully ready to be discharged before transferring them to a postacute care setting.

Critics of this option, including many hospitals, contend that the transfer policy (even in today's limited form) undermines one of the original incentives in the prospective payment system—to reduce hospital costs by discharging patients as soon as is practicable. Moreover, they argue, the policy creates an administrative burden for hospitals, which must verify discharge destinations, and may diminish the quality of care for some patients by encouraging hospitals to delay postacute care placements following hospital discharges.

570-10—Mandatory

Reduce Medicare Payments for Currently Covered Prescription Drugs

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	450	700	710	790	920	3,580	10,890

Supplementary Medical Insurance (Part B of Medicare) paid providers about $5.5 billion in 2001 for certain outpatient drugs. Prescription drugs are covered by Part B when they must be administered under a physician's supervision, as is the case with many drugs requiring injection or infusion. Medicare also pays for drugs that must be delivered by durable medical equipment covered under the program. In addition, some oral chemotherapy and antinausea drugs for cancer patients, immunosuppressive drugs for recipients of organ transplants, and vaccines and certain drugs related to end-stage renal disease are covered.

Medicare's payments for covered prescription drugs delivered at home and in physicians' offices have varied over time. Since 1998, those payments have been set at 95 percent of a drug's average wholesale price (AWP), which is a published list price established by the manufacturer. As a list price, however, the AWP is not the actual price that providers pay for drugs. Pegging Medicare's payment to the AWP has meant that providers and suppliers could profit from dispensing or administering Medicare-covered drugs.

This option would limit Medicare's reimbursements for most prescription drugs by reducing the allowed charge from 95 percent to 85 percent of the AWP and by limiting increases in that allowed charge to changes in the rate of inflation (as measured by the consumer price index for all urban consumers, excluding food and energy). As a result, net outlays for Medicare Part B would decline by $450 million next year and by a total of $3.6 billion between 2004 and 2008.

Proponents of this option point to recent evidence suggesting that acquisition costs for many Medicare Part B drugs are about one-fourth less than Medicare's reimbursement rate, on average. A 2001 report by the Inspector General of the Department of Health and Human Services examined pricing of the top 24 drugs that constitute 80 percent of Part B drug spending. The report concluded that if Medicare's reimbursement rates had been set at those drugs' acquisition costs, spending on the drugs would have been reduced by 25 percent, or $761 million. An attempt by the Centers for Medicare and Medicaid Services (CMS) to use market forces to gauge acquisition costs yielded similar results. CMS included several nebulizer drugs in a competitive-bidding demonstration project covering durable medical equipment and related supplies in Texas. On the basis of preliminary data, CMS reported that the reimbursement amounts set for those drugs using competitive bids were about 26 percent below the typical Part B reimbursement rate.

Opponents of this option argue that it would encourage manufacturers to introduce new drugs at elevated AWPs in order to restore profit margins for physicians and other suppliers. Physicians would prescribe newly introduced drugs more quickly as a result. Therefore, the option's effectiveness in limiting the growth of Part B spending would gradually erode as new drugs replaced older ones in the mix of covered drugs. (Another approach for approximating the acquisition costs of Medicare Part B drugs would be to require manufacturers to report their average sales price for a drug, including discounts and rebates. The reimbursement rate could be based on that reported transaction price.)

Critics of this option also claim that the profit margins physicians now get when they dispense drugs to Medicare patients subsidize their administrative costs. Savings would be reduced and patient care might suffer if patients were diverted from physicians' offices to hospital outpatient settings, where Medicare payment rates are higher. (The estimate of savings from this option accounts for that possibility.)

RELATED OPTION: 570-11

570-11—Mandatory

Require Competitive Bidding for High-Volume Items of Durable Medical Equipment

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	0	20	60	110	160	360	1,480

Medicare paid about $5.3 billion for supplies of durable medical equipment (DME), orthotics, and prosthetics last year, the Congressional Budget Office estimates. Suppliers of DME are paid according to a fee schedule that reflects their historical charges to Medicare rather than current market prices. Both the General Accounting Office and the Inspector General of the Department of Health and Human Services (HHS) have determined that Medicare's payments for many of those items far exceed the prices that other insurers pay or the prices charged in retail stores.

The Balanced Budget Act of 1997 authorized HHS to conduct several competitive-bidding demonstrations for durable medical equipment. Two such demonstrations have taken place: first in Polk County, Florida, and more recently in San Antonio, Texas. Bidders competed on the basis of price and quality for several categories of medical supplies. (Some of those categories differed in the two demonstrations, but oxygen supplies and hospital beds were included in both cases.) Only a limited number of bidders were selected as Medicare suppliers for each product, and other suppliers were generally not permitted to provide those products to fee-for-service Medicare beneficiaries in the area. Savings from the Florida competition averaged 17 percent across all product categories and were as high as 30 percent for hospital beds. Based on the bids it received in San Antonio, HHS set payment rates that averaged about 20 percent less than Medicare's current fee schedule for the items covered by that demonstration.

Under this option, Medicare would use competitive bidding to buy high-volume DME supplies in all areas of the country that have large numbers of suppliers. Savings would probably be lower in some competitive-bidding areas than those seen in the demonstrations. Even so, using that approach to purchase just two high-volume DME items—oxygen supplies and hospital beds—would reduce Medicare outlays by about $20 million in 2005 and a total of $360 million through 2008. (Savings would not begin until 2005 because of the time needed to implement the competitive-bidding system.) HHS would incur additional administrative costs for implementation, which are not included in CBO's estimate —but those added costs would most likely represent only a small percentage of the savings shown here.

Supporters of competitive bidding note that Medicare beneficiaries pay 20 percent coinsurance on DME items, so lower prices for those items would reduce their out-of-pocket costs. In addition, beneficiaries pay about 25 percent of Medicare's costs for DME items through their monthly Medicare premiums, so the savings for Medicare would be accompanied by a proportional decrease in those premium payments.

Critics of competitive bidding raise several concerns. One is that beneficiaries could find it more difficult to obtain DME items that were competitively bid. Beneficiaries' access to suppliers has been a major consideration in determining the number of winning bidders in the HHS demonstrations. In addition, beneficiaries who were receiving durable medical equipment at the start of each demonstration were allowed to continue using the same supplier even if it was not one of the winning bidders. Initial evaluations in both Florida and Texas found that no significant access problems arose (and that lesser problems were resolved).

Another concern is that fewer suppliers of oxygen and hospital beds would be participating in Medicare under this option than under current law. In cases in which

Medicare represented a large share of the total market for those supplies, over time this option could reduce the extent of competition among suppliers or at least give HHS a large role in determining which suppliers were viable. Competitive bidding could also create financial hardship for suppliers that were not selected in the bidding process if Medicare was a major source of their revenue.

570-12—Mandatory

Increase Medicare's Premium for Supplementary Medical Insurance to 30 Percent of Benefit Costs

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	3,520	5,380	6,050	6,610	7,130	28,680	75,370

Medicare offers insurance coverage for physicians' services and hospital outpatient services through its Supplementary Medical Insurance (SMI) program, or Part B of Medicare. SMI benefits are partially funded from monthly premiums paid by enrollees, with the remainder funded from general federal revenues. Although the SMI premium was initially intended to cover 50 percent of the cost of benefits, that share declined between 1975 and 1983, reaching less than 25 percent. The drop occurred because premium increases were limited by the cost-of-living adjustment (COLA) for Social Security benefits (which is based on the consumer price index), but the per capita cost of the SMI program rose faster than that. Premiums are now set to cover about 25 percent of average SMI benefits for an aged enrollee.

This option would raise the SMI premium to cover 30 percent of the cost of Part B benefits, beginning in 2004. That increase would save $3.5 billion in 2004 and $28.7 billion over five years and would raise the 2004 premium for enrollees to $78.10 per month instead of $65.10. The estimated savings shown here assume a continuation of the current hold-harmless provisions, which ensure that no Medicare enrollee's monthly Social Security benefit will fall because the dollar amount of the Social Security COLA is smaller than the dollar increase in the SMI premium. (SMI premiums are deducted from Social Security checks for most enrollees.)

Advocates of higher premiums argue that unlike proposals such as boosting cost-sharing requirements, which could substantially raise out-of-pocket costs for SMI enrollees who become seriously ill, this option would affect enrollees broadly and raise their costs only a little. Moreover, the option need not affect enrollees with income below 120 percent of the federal poverty line and few assets because they are eligible to have Medicaid pay their Medicare premiums (although not everyone who is eligible for Medicaid applies for benefits).

Critics of this option argue that low-income enrollees who are not eligible for Medicaid could find the higher premiums burdensome. A few might drop SMI coverage and either do without care or turn to sources of free or reduced-cost care, which could increase demands on local governments. In addition, states' expenditures would rise because states would pay part of the higher premium costs for those Medicare enrollees who also receive Medicaid benefits.

RELATED OPTION: 570-13

570-13—Mandatory

Tie Medicare's Premium for Supplementary Medical Insurance to Enrollees' Income

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	1,310	2,030	2,460	2,920	3,360	12,080	38,800

Instead of increasing the basic premium for Supplementary Medical Insurance (SMI) to 30 percent of benefit costs for all enrollees (option 570-12), this option would collect relatively more from higher-income enrollees. For example, individuals with modified adjusted gross income of less than $50,000 and couples with income below $75,000 would continue to pay the current premium, set at 25 percent of SMI costs per aged enrollee. But premiums would rise progressively for higher-income enrollees, reaching 50 percent of costs for individuals with income of more than $100,000 and for couples with income exceeding $150,000. Those premiums might have to be collected through the income tax system, so that rates could be aligned with income, rather than deducted from Social Security checks, as they are now for most enrollees.

If this option took effect on January 1, 2004, savings would total $1.3 billion in 2004 and $12.1 billion over the 2004-2008 period. Those estimates assume that the current hold-harmless provisions would continue only for people subject to the basic 25 percent premium. (The hold-harmless provisions ensure that no Medicare enrollee's Social Security check will decline because the dollar increase in the SMI premium exceeds the dollar amount of the Social Security cost-of-living adjustment.)

Proponents of this option argue that it would affect only a small fraction of SMI enrollees. Roughly 84 percent of enrollees would still pay the basic 25 percent premium, only 4 percent would pay the maximum premium, and 12 percent would pay an amount in between.

Opponents of this option counter that enrollees subject to the income-related premiums could pay substantially more than they do today. For example, the maximum premium for 2004 would be $126.60 per month instead of the $65.10 projected under current law. That increase might lead some enrollees to drop out of the SMI program. Enrollees with retiree health plans that do not require Medicare enrollment (mainly retired government employees) would be most likely to drop SMI coverage. Some healthy enrollees who have no other source of health insurance might do so as well, if they were not averse to the risk that they could incur large health care costs.

RELATED OPTION: 570-12

570-14—Mandatory

Index Medicare's Deductible for Supplementary Medical Insurance Services

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	100	200	300	400	600	1,600	8,300

The Supplementary Medical Insurance (SMI) program has a number of cost-sharing requirements for enrollees, including an annual deductible (the amount that enrollees must pay for services before the government shares responsibility). That deductible is now $100 a year.

This option would increase the SMI deductible each year, beginning in 2004, for the annual growth in total spending per enrollee for SMI services. That change would save the program $100 million in 2004 and $1.6 billion over five years.

Supporters of an increase point out that the SMI deductible has been raised only three times since Medicare began in 1966, when it was set at $50. Then, the deductible equaled roughly 45 percent of average annual per capita charges under the SMI program, whereas by 2000 it equaled just 3 percent. Moreover, supporters say, raising the deductible would give enrollees a greater economic incentive to use medical care prudently. Even with the increase, enrollees would not pay significantly more out of pocket. In 2004, the deductible would be $104, so no enrollee's out-of-pocket costs would rise by more than $4 in that year.

Critics of a higher deductible argue that over time, the additional out-of-pocket costs under this option might discourage some low-income enrollees who are not eligible for Medicaid from seeking needed care. In addition, states' costs would rise because their Medicaid programs pay the deductibles for Medicare enrollees who also receive benefits under Medicaid.

570-15—Mandatory

Simplify and Limit Medicare's Cost-Sharing Requirements

						Total	
(Millions of dollars)	2004	2005	2006	2007	2008	2004-2008	2004-2013
Outlay Savings	970	1,480	2,290	2,730	3,130	10,610	36,580

In Medicare's fee-for-service sector, cost-sharing requirements vary significantly by the type of service provided. For example, Medicare beneficiaries who are hospitalized must pay a Part A deductible of more than $800 per spell of illness and can be subject to increasing levels of coinsurance for very long hospital stays. For outpatient services covered under Part B of Medicare, the deductible has remained $100 a year since 1991. Beyond that deductible, beneficiaries pay 20 percent of the allowable cost of most Part B services. Certain Medicare services, such as home health visits or clinical laboratory tests, require no cost sharing. As a result of those variations, beneficiaries may not consider relative costs accurately when choosing among alternative treatments. Moreover, if Medicare patients experience high medical costs, they can face unlimited cost-sharing expenses, since the program does not cap those expenses.

Medicare could simplify and limit cost-sharing requirements in its fee-for-service sector while also reducing federal costs. This option would replace the current complicated mix of cost sharing with a single combined deductible (covering all services in Parts A and B of Medicare), a uniform coinsurance rate of 20 percent for amounts above that deductible, and a cap on each beneficiary's total cost-sharing liabilities. If the option took effect on January 1, 2004, federal savings would total $970 million in 2004 and $10.6 billion over five years. The combined deductible would be $600 in 2004, and the cap on total cost sharing would be $3,400. In later years, those amounts would grow at the same rate as per capita Medicare benefits.

Those estimates assume that the new Medicare cost-sharing rules would be mandatory. In contrast, some recent Congressional proposals to revise fee-for-service Medicare would allow beneficiaries to decide whether they wanted to enroll under new cost-sharing requirements. If participation was voluntary rather than mandatory, savings from this option would fall significantly and could even turn into costs—particularly if the only participants were people who would pay less in cost sharing under the new rules than under current law.

Supporters of this option argue that it would have several advantages besides reducing federal spending for Medicare. First, the option would cap beneficiaries' out-of-pocket expenses, which could particularly help people who have serious illnesses or require hospitalization. Second, it would increase the incentives for enrollees to use medical services prudently. By design, deductibles and coinsurance are mechanisms for exposing beneficiaries to some of the financial consequences of their choices about the use of health services. This option's combined deductible would be higher than the deductible under Part B (the vast majority of Medicare enrollees do not need to pay the Part A deductible in a given year); thus, people without supplemental coverage or with a medigap plan that did not cover the deductible would face the full cost for a larger proportion of the services they used. Moreover, the uniform coinsurance rate of 20 percent on all services would encourage enrollees without supplemental coverage to consider relative costs when choosing among various treatments. Third, the resulting reductions in costs for Medicare's Part B program would translate into lower premiums for enrollees.

Although this option is consistent with steps that some private insurers and employers are taking to control the growth of health spending, opponents would argue that, in general, it would increase Medicare's cost-sharing requirements for most enrollees. Cost-sharing expenses would fall substantially for about 8 percent of enrollees, stay the same for nearly 16 percent, and rise modestly for the other 77 percent. However, most Medicare beneficiaries would be insulated from those direct effects be-

cause they have supplemental coverage; instead, some would see the effects in the form of higher premiums for supplemental policies. In addition, the option would make beneficiaries responsible for paying coinsurance on certain services—such as home health care—that are not now subject to cost sharing, which would increase administrative costs for some types of health care providers.

RELATED OPTIONS: 570-16 and 570-17

570-16—Mandatory

Restrict Medigap Coverage of Medicare's Cost Sharing

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	1,860	2,830	3,030	3,220	3,440	14,390	36,510

Cost-sharing requirements in Medicare's fee-for-service sector can be substantial, so most beneficiaries seek some form of supplemental insurance coverage. In particular, about 30 percent of fee-for-service enrollees buy individual private insurance (or medigap) policies that are designed to cover all or most of the cost sharing that Medicare requires. On average, medigap policyholders use at least 25 percent more services than Medicare beneficiaries who have no supplemental coverage and about 10 percent more services than beneficiaries who have supplemental coverage from their former employer (which tends to reduce but not eliminate their cost-sharing liabilities). However, it is taxpayers (through Medicare)—not medigap insurers or policyholders—who pay most of the cost of those additional services.

Federal costs for Medicare could be reduced if medigap plans were restructured so that policyholders faced some cost sharing for Medicare services while still having their out-of-pocket costs limited. This option would bar medigap policies from paying any of the first $600 of an enrollee's cost-sharing liabilities for calendar year 2004 and would limit coverage to 50 percent of the next $2,800 in Medicare cost sharing. (All further cost sharing would be covered, so enrollees could not pay more than $2,000 in cost sharing that year.) If those dollar limits were indexed to growth in the average value of Medicare's costs for later years, savings would total almost $1.9 billion in 2004 and $14.4 billion over five years. Those estimates assume that all current and future medigap policies are required to meet the new standards; savings would be much lower if—as in some recent proposals—the new medigap design was optional.

Proponents of this option argue that most Medicare enrollees who have medigap policies would be better off financially as a result. Because insurers that offer medigap plans must compete against each other for business, they would most likely reduce premiums to reflect the lower costs of providing the new policies. Indeed, most medigap policyholders would have smaller annual expenses under this option because their medigap premiums would decline by more than their cost-sharing liabilities would increase. (Part of the reason is that premiums for medigap policies are generally somewhat higher than the average cost-sharing liabilities that the policies cover, because of the administrative and other costs that medigap insurers incur, but the primary reason is that most of those liabilities are generated by a relatively small number of policyholders.) Greater exposure to Medicare's cost sharing could even lead some medigap policyholders to forgo treatments that would yield them few or no net health benefits. Indirectly, the decline in Medicare's costs would also cause that program's monthly premiums (which cover about 25 percent of costs for Part B of Medicare) to fall, so other Medicare beneficiaries would also be better off.

This option could have several drawbacks, however. Medigap policyholders would face more uncertainty about their out-of-pocket costs. For that reason, some policyholders might object to being barred from purchasing first-dollar coverage, even if they would be better off financially in most years under this option. (Most medigap policyholders buy optional coverage of the $100 Part B deductible; new high-deductible medigap policies have attracted only limited enrollment despite their substantially lower premiums.) Moreover, in any given year, about a quarter of medigap policyholders would incur higher total costs under this option than they would under the current system, and those with expensive chronic conditions might be worse off year after year. Finally, the decline in use of services by medigap policyholders (which would generate the federal savings under this option) might adversely affect their health in some cases.

RELATED OPTIONS: 570-15 and 570-17

570-17—Mandatory

Combine Medicare Cost-Sharing Changes with Medigap Restrictions

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	2,980	4,530	5,540	6,190	6,820	26,070	75,530

The savings from simplifying and limiting Medicare's cost-sharing requirements (option 570-15) could be greatly increased by restricting medigap coverage at the same time (option 570-16). In fact, savings from carrying out both changes together would be greater than the sum of savings from either one alone.

Under this option, medigap plans would be prohibited from covering any of the $600 combined deductible for Medicare in 2004 (described in option 570-15) and could not cover more than 50 percent of remaining cost-sharing requirements, up to a limit of $3,400 a year on out-of-pocket spending. Such a medigap policy would correspond to the one described in option 570-16, with coverage limited to 50 percent of the next $2,800 in Medicare cost sharing (thus capping out-of-pocket expenses at $2,000 in 2004). If those various dollar limits were indexed to growth in per capita benefits paid by Medicare, this option would save almost $3.0 billion next year and $26.1 billion over the 2004-2008 period.

Those estimates assume that participation in Medicare's new cost-sharing requirements would be mandatory and that all medigap policies would be required to follow the new standards. That approach differs from some recent Congressional proposals, in which beneficiaries could decide whether they wanted to enroll in a new cost-sharing system. With voluntary participation, savings would be lower—or could even become costs—if the only enrollees in the new program were people who would pay less in cost sharing than they would under current law.

This option would appreciably strengthen incentives for more prudent use of medical services by raising the initial threshold of health costs that most Medicare beneficiaries faced and by prohibiting medigap plans from covering that deductible or more than half of Medicare's additional cost-sharing requirements. As a result, the five-year savings from this option would be $1.1 billion larger than the sum of savings achieved from options 570-15 and 570-16.

Despite the new catastrophic cap, which would protect Medicare enrollees against very large out-of-pocket expenses, some enrollees would object to this option or any other policy that denied them access to first-dollar supplemental coverage.

RELATED OPTIONS: 570-15 and 570-16

570-18—Mandatory

Collect Deductible and Coinsurance Amounts for Clinical Laboratory Services Under Medicare

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	670	1,040	1,120	1,200	1,290	5,330	13,440

Medicare currently pays 100 percent of the approved fee for clinical laboratory services provided to enrollees. Medicare's payment is set by a fee schedule, and providers must accept that fee as full payment for the service. For most other services provided under Medicare's Supplementary Medical Insurance (SMI) program, beneficiaries are subject to both a $100 deductible and a coinsurance rate of 20 percent.

This option would impose the SMI program's usual deductible and coinsurance requirements on laboratory services, beginning on January 1, 2004. That change would yield appreciable federal savings: $670 million in 2004 and $5.3 billion over five years.

Supporters of this option argue that besides reducing Medicare's costs, this change would make cost-sharing requirements under the SMI program more uniform and therefore easier to understand. Moreover, enrollees might be less likely to undergo laboratory tests with little expected benefit if they paid part of the costs themselves.

Critics of this option counter that enrollees' use of laboratory services would probably not be substantially affected because decisions about what tests are appropriate are generally left to physicians, whose judgments do not appear to depend on enrollees' cost-sharing liabilities. Thus, only a small part of the expected savings from this option would stem from more prudent use of laboratory services; the rest would reflect the transfer to enrollees of costs now borne by Medicare. Moreover, the billing costs of some providers, such as independent laboratories, would be higher under this option because those providers would have to bill both Medicare and enrollees to collect their full fees. (Currently, they have no need to bill enrollees directly for clinical laboratory services.) In addition, states' Medicaid costs would increase for Medicare enrollees who also receive Medicaid benefits.

570-19—Mandatory

Reduce Medicare Payments for Home Health Care

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	280	790	1,400	2,160	2,560	7,200	25,420

Last year, Medicare paid about $10 billion for home health care services—including intermittent skilled nursing care as well as physical therapy and speech therapy—for beneficiaries who were deemed to be homebound. Medicare spending on home health services grew rapidly in the mid-1990s, when agencies were reimbursed separately for each home health visit, but fell sharply after new payment systems were implemented under the Balanced Budget Act of 1997. Since 2001, home health agencies have generally been paid a fixed amount for providing all covered services for a 60-day period (known as a home health "episode"). The payments are adjusted prospectively on the basis of factors related to each beneficiary's expected need for care; in 2001, payments ranged from $1,114 to $5,947 per episode. Under current law, payments per episode are generally indexed to annual changes in input costs.

Although the per-episode payment rates for 2003 were cut by about 7 percent because of statutory reductions in payment limits, an analysis by the General Accounting Office (GAO) suggests that those payments will exceed home health agencies' estimated costs by an average of 25 percent. (GAO found that payments outstrip average costs in 75 of Medicare's 80 payment categories for home health care, with the extent of the difference ranging from a few percent to as much as 72 percent for the most common payment categories.) The disparity between home health payments and agencies' costs primarily reflects the fact that the per-episode payment amounts were based on the number of visits made under the previous payment system, but the number of visits per episode has fallen by about one-third under the current payment system.

This option would freeze the base payment for each home health episode at its 2003 level ($2,159) through 2007 to gradually narrow the gap between payments and costs. In addition, the option assumes that adjustments would be made among the 80 home health payment categories to bring payments more closely into line with costs in each case. Those changes would reduce Medicare outlays by $280 million in 2004 and by $7.2 billion over the 2004-2008 period. (The estimates of savings assume that cuts in average payment levels will be partially offset by an increase in the share of patients assigned to higher-payment categories, a practice called "up-coding." The estimates also take into account other responses that reduce the effect of those cuts on total spending.)

Advocates of this option argue that if average per-episode costs for home health agencies grew at the rate of inflation, this reduction would still leave average payments at least 10 percent above agencies' average costs for 2007 and beyond. That difference would provide a margin for agencies whose costs were slightly higher than average or that experienced faster cost growth.

Opponents of this option argue that it could reduce access to home health services for Medicare beneficiaries. If Medicare payments were moved closer to the average costs of home health agencies, agencies with substantially higher costs would eventually have to reduce their operating expenses or cease participating in the program. If the remaining agencies did not have enough capacity to serve all of the Medicare beneficiaries requiring home health care—or could not do so at costs that were at or below the revised payment rates—some beneficiaries would have difficulty receiving home health services. Lower payment rates could also lead some of those agencies to reduce the level or quality of services they provided to beneficiaries during a 60-day episode (although such concerns arise under any system of fixed prospective payments).

RELATED OPTION: 570-20

570-20—Mandatory

Impose a Copayment Requirement on Home Health Episodes Covered by Medicare

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	1,000	1,600	1,800	2,000	2,300	8,700	24,900

Medicare's spending for home health care dropped during the late 1990s. But the Congressional Budget Office projects that use of home health services and the resulting costs will grow rapidly over the coming decade. One reason for the unrestrained growth is that Medicare beneficiaries are not required to pay any of the cost of home health services covered by the program.

This option would charge beneficiaries a copayment amounting to 10 percent of the total cost of each home health episode (60-day period of services) covered by Medicare, beginning on January 1, 2004. That change would yield net federal savings of $1 billion in 2004 and $8.7 billion over five years.

By shifting part of the cost of each home health episode to beneficiaries, this option would reduce the use of home health services—at least among the less than 10 percent of enrollees in fee-for-service Medicare who do not have supplementary coverage for their cost-sharing expenses. However, it would also increase the risk of very large out-of-pocket costs for those enrollees. Little or no drop in use would be expected among the more than 90 percent of enrollees who have Medicaid, medigap, or employment-based supplementary coverage. Thus, the 31 percent of enrollees with private medigap policies would be likely to face higher premiums, and the costs of the Medicaid program would rise on behalf of the 17 percent of Medicare enrollees who also receive Medicaid benefits.

RELATED OPTION: 570-19